U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 April 2003

In the Matter of
BILLY J. RICHARDSON
Claimant

Case No. 2003-BLA-00004

v.

SEA B MINING COMPANY
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER

DENYING MODIFICATION

This case comes on a request for hearing filed by the Claimant, **BILLY J. RICHARDSON**, pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§901 *et seq.* (the Act.). Claimant originally filed a claim for Black Lung benefits on February 28, 1994, however, that claim was rejected and not pursued, and is administratively final. A duplicate claim was filed December 27, 1995. This case involves a request to modify prior determinations in that claim.

At hearing in Bristol, Virginia on February 27, 2003, the Claimant appeared and testified. Eighty nine (89) Director's Exhibits ("DX" 1 through DX 89) were admitted into evidence (Transcript, "TR" at pages 6, 8). The Claimant submitted two exhibits (hereinafter "CX" 1 and CX 2), which were admitted (Tr 12). Fifteen(15) Employer exhibits ("EE" 1 through EE 15) were admitted without objection (TR 20-21). The parties were given thirty days post receipt of the transcript to file simultaneous briefs, with the opportunity to file replies within 15 days of receipt of the opening briefs. The Employer's brief was filed March 27, 2003. Although the record remained open to receive the Claimant's brief, none has been received.

The 1995 claim was initially approved by the Department of Labor on April 11, 1996 (DX 16). However, the Employer requested a hearing, and after a hearing on the duplicate claim, Judge Richard A. Morgan denied benefits on June 23, 1997. DX 40. He determined that Claimant had proved that the new evidence showed claimant had become disabled by a respiratory impairment. However, considering all the evidence, Judge Morgan found Claimant had failed to prove the existence of pneumoconiosis or that pneumoconiosis caused or contributed to claimant's disability. Id. Claimant appealed to the Benefits Review Board ("BRB" or "Board") and the Board affirmed the denial of benefits and dismissed the appeal. DX 42.

Claimant requested modification on September 23, 1998. DX 43. The DOL, after considering the evidence submitted by Claimant and by Sea "B" Mining, it denied modification and Claimant requested a hearing. DX 48 and 49. DOL referred the claim to the Office of Administrative Law Judges on June 23, 1999. DX 55. Judge Richard K. Malamphy, after holding a hearing on November

3, 1999 (DX 66), issued his Decision & Order denying modification and benefits on March 23, 2000.DX 72. Claimant appealed and the Board affirmed the denial on April 19, 2001. DX 73 and 76.

Claimant again requested modification and submitted new medical evidence on March 12, 2002. DX 77. DOL issued its Proposed Decision & Order denying modification on July 2, 2002. DX 82. Claimant requested a hearing on July 8, 2002. DX 83. The Director referred the claim to the Office of Administrative Law Judges on September 24, 2002. DX 88-89.

At hearing, the Claimant was called to testify (TR 12). He stated that he worked forty (40) years in underground mines and last worked in May, 1993 (TR 13). Mr. Richardson alleged that since March, 2000, his breathing problems have gotten worse. He testified, "I can't do nothing with no strain in it." (Tr 14). For example, he can no longer perform yard work. He testified that his treating physician is Dr. Randolph Forehand, who prescribed three types of breathing medications, including Advair and Combvent which he has to take several times a day, each (Tr 14- 16). The dosage of the liquid medication that he takes has been increased since 2000 (Tr 18). However, on cross examination, he admitted that the dosages in the nebulizer he is supposed to use has not changed (Tr 19). He has not worked since he left mining. Although he used to smoke, he testified that he quit "several years ago." Tr 16.

The parties stipulated that the 1995 application is in question (Tr 8) and that this is a modification claim (Tr 5). Timeliness is not an issue (Tr 10). The Employer does not contest that it is the responsible operator (TR 10). Moreover, although the Director contests whether the Claimant is totally disabled, the Employer does not (Tr 10).

Burden of Proof

"Burden of proof" as used in the this setting and under the Administrative Procedure Act[1] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof.[2] "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)4. The drafters of the APA used the term "burden of proof' to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 114 S.Ct. 2251 (1994).[3]

A claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition,

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[1] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with "the APA"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[2] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP [Sainz]***, 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[3] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev. 1981).

not simply the burden of production, the obligation to come forward with evidence to support a claim.[4] Therefore, the claimant cannot rely on the Director to gather evidence. A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1- 860 (1985).

Modification

33 U.S.C. 922 provides:

> [u]pon his own initiative, or upon the application of any party in interest, ... on the ground of a change in conditions or because of a mistake in a determination of fact by the deputy commissioner, the deputy commissioner may ... review a compensation case ... in accordance with the procedure prescribed in respect of claims in section 919 . . . .

33 U.S.C. 922.

The modification provisions at § 22 of the Longshore and Harbor Worker's Compensation Act, 33 U.S.C. § 922, are incorporated into the Black Lung Benefits Act by 30 U.S.C.§ 932(a), and they provide the statutory authority to modify orders and awards. An award in a black lung claim may be modified (increased, decreased, or terminated) at the behest of the claimant, employer, or district director upon demonstrating that a "change in conditions" has occurred or there is a "mistake in a determination of fact." 20 C.F.R. § 725.310. An allegation of a mistake or change of law, however, does not constitute proper grounds for modification. ***Donadi v. Director, OWCP***, 12 B.L.R. 1-166 (1989).

In evaluating a request for modification under § 725.310, it is not enough that the administrative law judge conduct a substantial evidence review of the district director's finding. Rather, the claimant is entitled to de novo consideration of the issue. ***Kovac v. BCNR Mining Corp***., 14 B.L.R. 1-156 (1990), *aff'd on recon*., 16 B.L.R. 1-71 (1992); ***Dingess v. Director, OWCP***, 12 B.L.R. 1-141 (1989); ***Cooper v. Director, OWCP***, 11 B.L.R. 1-95 (1988). See also 20 C.F.R. § 725.310(c).

The circuit courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. See ***General Dynamics Corp. v. Director, OWCP***, 673 F.2d 23 (1st Cir. 1982); ***Director, OWCP v. Drummond Coal Co.***, 831 F.2d 240 (11th Cir. 1987); ***Lukman v. Director, OWCP***, 11 B.L.R. 1-71 (1988) (Lukman II). See, e.g., ***Amax Coal Co. v. Franklin***, 957 F.2d 355 (7th Cir. 1992) (letter from miner's physician indicating that the miner may have black lung disease did not establish a "change in conditions," but was sufficient to warrant reopening the claim based upon a "mistake in a determination of fact").

In ***Jessee v. Director, OWCP***, 5 F.3d 723 (4th Cir. 1993), the Fourth Circuit held that a request for modification may be based upon an allegation "that the ultimate fact -- disability due to pneumoconiosis -- was mistakenly decided . . .." The Board has yet to comprehensively define the phrase "mistake in a determination of fact." Several circuit courts of appeals have, however, concluded that it is to be interpreted broadly and includes any challenge to the ultimate issues of whether the miner is totally disabled due to pneumoconiosis.

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[4] *Id*., also see ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

Summary of Medical Evidence
X-Rays

EX. NO	X-Ray Date Reread	Facility Physician	Qual / Cert	Submitted	Readings / Comments
DX 46.4	5/15/1965	HHCV CUNNINGHAM	/R [1]	2/16/98	NEG FOR SILICOSIS
DX 46.5	3/13/1970	HHCV HOLT	/R	2/16/98	WNL
DX 46.6	8/3/1973	HHCV DODRILL	/ R	2/16/98	0
DX 46.7	3/15/1976	HHCV CUNNINGHAM	/ R	2/16/98	NEG FOR ACUTE ABNORMALITY
DX 1.27.4	1/23/1984 7/30/1996	SUTHERLAND CLINIC, INC WIOT	B / R	8/19/96	NEGATIVE
DX 1.27.5	1/23/1984 7/31/1996	SUTHERLAND CLINIC, INC SPITZ	B / R	8/19/96	NEGATIVE
DX 1.29.4	1/23/1984 9/11/1996	SUTHERLAND CLINIC, INC PENDERGRASS	B / R	9/23/96	NEGATIVE FOR CWP
DX 1.29.2	3/18/1994 9/11/1996	BRISTOL FAMILY MED CEN PENDERGRASS	B / R	9/23/96	NEGATIVE FOR CWP, SCARRING AT LUNG BASES
DX 1.32.2	3/18/1994 10/4/1996	BRISTOL FAMILY MED CEN WIOT	B / R	11/11/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.32.3	3/18/1994 10/10/1996	BRISTOL FAMILY MED CEN SPITZ	B / R	11/11/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.20.4	4/5/1994 5/30/1996	CVMC SPITZ	B / R	6/7/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.20.5	4/5/1994 5/31/1996	CVMC WIOT	B / R	6/7/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 15	4/5/1994 4/6/1994	IOSIF FISHER	B / R		NO CWP
DX 16	4/5/1994 4/25/1994	IOSIF SARGENT	B / R		NO CWP
DX 1.24.2	7/19/1994 6/13/1996	SOUTHWEST VA MED CEN SPITZ	B / R	6/26/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.24.3	7/19/1994 6/17/1996	SOUTHWEST VA MED CEN WIOT	B / R	6/26/96	NEGATIVE FOR CWP, EMPHSEMA

DX 1.29.6	7/19/1994 9/11/1996	SOUTHWEST VA MED CEN PENDERGRASS	B / R	9/23/96	NEGATIVE
DX 1.27.2	8/18/1994 7/3/1996	SUTHERLAND CLINIC, INC. WIOT	B / R	8/19/96	NEGATIVE
DX 1.27.3	8/18/1994 7/12/1996	SUTHERLAND CLINIC, INC. SPITZ	B / R	8/19/96	NEGATIVE
DX 1.29.5	8/18/1994 9/11/1996	SUTHERLAND CLINIC, INC. PENDERGRASS	B / R	9/23/96	NEGATIVE
DX 21.2	8/18/1994	SUTHERLAND CLINIC, INC. JPS	/ U	9/5/94	3/2 P/Q
DX 1.11	1/17/1996 2/2/1996	CVC NAVANI	B / R		P/S 0/1
DX 1.12	1/17/1996	CVC FOREHAND	O / O		NO CWP
DX 1.20.2	1/17/1996 5/30/1996	THE CLINIC SPITZ	B / R	6/7/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.20.3	1/17/1996 5/31/1996	THE CLINIC WIOT	B / R	6/7/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.23.4	5/22/1996	BRMC SARGENT	B / P	6/24/96	0/0
DX 1.24.4	5/22/1996 6/17/1996	MIDWAY MEDICAL GROUP WIOT	O / R	6/26/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.24.5	5/22/1996 6/13/1996	MIDWAY MEDICAL GROUP SPITZ	O / R	6/26/96	NEGATIVE FOR CWP, EMPHYSEMA
DX 1.29.3	5/22/1996 9/11/1996	MIDWAY MEDICAL GROUP PENDERGRASS	O / R	9/23/96	NEGATIVE FOR CWP, HYPEREXPANDED LUNGS, LUNG BASES CLEAR
DX 1.34.2	9/16/1996 11/6/1996	THE CLINIC SCOTT	B / R	11/26/96	NEGATIVE FOR CWP, HYPERINFLATION LUNGS COMPATIBLE W/ EMPHYSEMA
DX 1.34.3	9/16/1996 11/6/1996	THE CLINIC WHEELER	B / R	11/26/96	NEGATIVE FOR CWP, EMPHYSEMA W/ HYPERINFLATION LUNGS BLUNTING CPAs
DX 26.2	9/16/1996 1/9/1997	THE CLINIC FINO	B / P	1/21/97	NEGATIVE CV SUBMITTED
DX 43.9	9/16/1996	CVPI CRAWFORD	/ U	9/23/98	NO ACUTE ABNORMALITY WAS SEEN, CHR LUNG DIS W/ MILD INTERSTITIAL FIBROSIS
DX 31	1/7/1997 2/14/1997	CVMC CASTLE	B / P	3/20/97	S/S 0/1
DX 32	1/7/1997 3/26/1997	CVMC FINO	B / P	3/28/97	NEGATIVE

DX 33	1/7/1997 4/7/1997	CVMC WHEELER	B / R	4/10/97	NEGATIVE FOR CWP, HYPERINFLATION LUNGS COMPATIBLE W/ EMPHYSEMA, SCARS
DX 34	1/7/1997 4/7/1997	CVMC SCOTT	B / R	4/10/97	NEGATIVE FOR CWP, HYPERINFLATION LUNGS COMPATIBLE W/ EMPHYSEMA, FIBROSIS
DX 43.6	3/25/1998	CLINCH VALLEY PHYSICIANS CRAWFORD	/ R	9/23/98	COPD W/ INTERSTITIAL FIBROSIS
DX 45.2	3/25/1998 1/21/1999	THE CLINIC DAHHAN	B / P	2/12/99	NEGATIVE
DX 47.2	3/25/1998 2/15/1999	THE CLINIC SCOTT	B / R	2/25/99	NEGATIVE FOR CWP, HYPERINFLATION COMPATIBLE W/ EMPHYSEMA
DX 47.3	3/25/1998 2/17/1999	THE CLINIC WHEELER	B / R	2/25/99	NEGATIVE FOR CWP, HYPERINFLATION COMPATIBLE W/ EMPHYSEMA W/ DECREASED MARKINGS
DX 57.5	12/3/1998 8/16/1999	CVMC CASTLE	B / P	8/30/99	T/Q 0/1, EM
DX 58.2	12/3/1998 8/23/1999	CVMC DAHHAN	B / P	9/1/99	NEGAITVE FOR CWP, EMPHYSEMA
DX 60.2	12/3/1998 9/2/1999	CVMC WHEELER	B / R	9/16/99	NEGATIVE FOR CWP, EMPHYSEMA W/ HYPERINFLATION SLIGHTLY BLUNTING RIGHT CPA & PROBABLE DECREASED UPPER LUNG MARKINGS, MASS, CHECK FOR ENLARGED THYROID, POSSIBLE CALCIFIED GRANULOMA
DX 61.3	12/3/1998 10/1/1999	CVMC FINO	B / P	10/5/99	NEGATIVE FOR CWP, EMPHYSEMA CV SUBMITTED
DX 56.2	7/13/1999 8/13/1999	MIDWAY MEDICAL GROUP DAHHAN	B / P	8/24/99	NEGATIVE
DX 59.3	7/13/1999	MIDWAY MEDICAL GROUP MCSHARRY	/ P	9/13/99	NO CWP
DX 59.4	7/13/1999 7/19/1999	MIDWAY MEDICAL GROUP SCOTT	/ R	9/13/99	NO CWP, EM
DX 61.2	7/13/1999 7/21/1999	MIDWAY MEDICAL GROUP WHEELER	B / R	10/5/99	NEGATIVE FOR CWP, HYPERINFLATION W/ INCREASED AP DIAMETER CHEST COMPATIBLE W/ EMPHYSEMA OR POSSIBLE DEEP BREATH, POSSIBLE ASTHMA
DX 61.4	7/13/1999 10/1/1999	MIDWAY MEDICAL GROUP FINO	B / P	10/5/99	NEGATIVE FOR CWP, EMPHYSEMA
DX 63.2	10/26/1999 12/9/1999	THE CLINIC FINO	B / P	1/14/00	NEGATIVE FOR CWP, EMPHYSEMA
DX 63.3	10/26/1999 11/18/1999	THE CLINIC WHEELER	B / R	1/14/00	NEGATIVE FOR CWP, HYPERINFLATION FLATTENING DIAPHRAGM W/ DECREASED MARKINGS COMPATIBLE W/ EMPHYSEMA, CALCIFIED GRANULOMA FROM HEALED TB

DX 63.4	10/26/1999 11/17/1999	THE CLINIC SCOTT	B / R	1/14/00	NEGATIVE FOR CWP, HYPERINFLATION COMPATIBLE W/ EMPHYSEMA
DX 64.2	10/26/1999	THE CLINIC FOREHAND	B / O	11/9/99	BIBASILAR INTERSTITIAL LUNG DIS, S/T 1/0, A OPACITIES
EE 4	5/8/2001 12/5/2002	THE CLINIC SCOTT	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA OR DEEP BREATH
EE 5	5/8/2001 12/5/2002	THE CLINIC WHEELER	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W DEEP BREATH OR EMPHYSEMA, ARTERIOSCLEROSIS AORTIC ARCH
CX 1	1/7/2002 1/30/2002	THE CLINIC MILLER	B / R	12/31/02	1/0 p/s; PLEURAL THICKENING; COPD; EM; PI; W/NARRATIVE REPORT & CV
DX 77.2	1/7/2002	THE CLINIC FOREHAND	B/O	3/12/02	1/1 p/s; RETICULONODULAR LUNG DISEASE; COPD; LUNGS HYPERINFLATED
DX 85.2	1/7/2002 6/6/2002	THE CLINIC WHEELER	B / R	8/9/02	NEGATIVE FOR CWP, HYPERINFLATION COMPATIBLE W/ DEEP BREATH OR EMPHYSEMA
DX 85.3	1/7/2002 6/7/2002	THE CLINIC SCOTT	B / R	8/9/02	NEGATIVE FOR CWP, HYPERINFLATION EMPHYSEMA VS. DEEP BREATH
DX 85.4	1/7/2002 6/7/2002	THE CLINIC SCATARIGE	B / R	8/9/02	NEGATIVE FOR CWP, HYPERINFLATION EMPHYSEMA VS. DEEP BREATH
DX 85.8	4/18/2002 5/13/2002	BUCHANAN GEN. HOSP FINO	B/P	8/9/02	COMPLETELY NEGATIVE
DX 86.2	4/18/2002 6/6/2002	BUCHANAN GEN. HOSP. HAYES	B / R	8/14/02	NEGATIVE
EE 3	4/18/2002 8/27/2002	BUCHANAN GEN. HOSP SCATARIGE	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W DEEP BREATH OR EMPHYSEMA, ATHEROSCLEROTIC AORTIC ARCH
EE 10	9/17/2002 1/29/2003	THE CLINIC SCATARIGE	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA
EE 11	9/17/2002 12/24/2002	THE CLINIC DAHHAN	B / P	2/7/03	NEGATIVE FOR CWP, EMPHYSEMA
EE 9	9/17/2002 1/29/2003	THE CLINIC SCOTT	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA
EE 14	12/9/2002	CVMC CASTLE	B / P	2/7/03	0/1 t/s; BU; EM
EE 6	12/9/2002 1/29/2003	CVMC SCOTT	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA
EE 7	12/9/2002 1/29/2003	CVMC SCATARIGE	B / R	2/7/03	NEGATIVE FOR CWP, PULMONARY HYPERINFLATION C/W EMPHYSEMA
EE 8	12/9/2002	CVMC	B / P	2/7/03	NEGATIVE FOR CWP, HYPERAERATION

	1/15/2003	FINO			
EE 12	12/16/2002 1/29/2003	HAYSI ER & MED. CLINIC SCOTT	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA
EE 13	12/16/2002 1/29/2003	HAYSI ER & MED. CLINIC SCATARIGE	B / R	2/7/03	NEGATIVE FOR CWP, HYPERINFLATION C/W EMPHYSEMA

Arterial Blood Gas Studies

EX. NO.	ABG Done Reviewed	Facility Physician	PCO2	$PO2^2$	Submitted	Readings / Comments
DX 14	4/5/1994	IOSIF	34.1* 31**	71.7* 78.2**		
DX 1.10	1/17/1996	CVC FOREHAND	35* 33**	63* 71**		
DX 1.8	1/17/1996 2/12/1996	CVC MICHOS				VALID
DX 1.23.5	5/22/1996	MIDWAY MEDICAL GROUP SARGENT	36.7* 36.3**	64.1* 70.6**	6/24/96	
DX 43.11 & 25.2	9/16/1996	CVC FOREHAND	34*	73*	12/31/96	
DX 28	1/7/1997	CVMC CASTLE	35.1*	69.4*	3/25/97	
DX 43.5	3/25/1998	CVC FOREHAND	40*	67*	9/23/98	
DX 57.3	12/3/1998	CVMC CASTLE	37*	61.2*	8/30/99	COHB-1.2
DX 59.5	7/13/1999	MIDWAY MEDICAL GROUP MCSHARRY	37*	73*	9/13/99	
DX 65.4	10/26/1999	THE CLINIC FOREHAND	36*	67*	11/9/99	
DX 85.6	4/18/2002	BUCHANAN GEN. HOSP. FINO	38.4*	74.5*	8/9/02	
EE 14	12/9/2002	CVMC CASTLE	36*	67.6*	2/7/03	NORMAL RESTING ABG

Pulmonary Function Studies

EX. NO.	PFS Taken Reviewed Submitted	Facility Physician Comments	FEV1	FVC	MVV	TR	AGE	HGHT	COOP
DX 46.3	8/3/1973 2/16/1998	HHCV ABERNATHY	3.54	4.53	138	Y	37	68	G
DX 10	4/5/1994 5/1/1994	IOSIF MICHOS INVALID							
DX 9	4/5/1994	IOSIF	1.91 2.06	4.53 3.99	71.5 75.6	Y Y	58	66.25	G
DX 11	6/9/1994	IOSIF REPEAT PFS DOES NOT CHANGE PREV OPINION	1.93	3.58	71	Y	58	69	G
DX 12	6/9/1994 7/12/1994	IOSIF MICHOS VALID							
DX 1.7	1/17/1996	CVC FOREHAND	1.44 1.78	2.95 3.55	57 73	Y Y	59	67	G
DX 1.8	1/17/1996 2/12/1996	CVC MICHOS VALID							
DX 1.23.6	5/22/1996 6/24/1996	MIDWAY MEDICAL GROUP SARGENT	1.71 2.07	3.31 3.85	73	Y Y	60	68	G
DX 43.10	9/16/1996 9/23/1998	CVC FOREHAND	1.56 1.8	2.74 3.26	60 65	Y Y	60	67	S
DX 29	1/7/1997 3/25/1997	CVMC CASTLE	1.54 1.54	3.12 3.46	70 59	Y Y	60	66	
DX 43.4	3/25/1998 9/23/1998	CLINCH VALLEY PHYSICIANS FOREHAND	1.21 1.59	2.5 3.16		Y Y	62	67	G
DX 57.4	12/3/1998 8/30/1999	CVMC CASTLE	1.41 1.66	3.17 3.64	53 62	Y Y	62	67	G
DX 59.6	7/13/1999 9/13/1999	MIDWAY MEDICAL GROUP MCSHARRY	1.35 1.64	3.48 4.21	54	Y	63	66	G
DX 65.3	10/26/1999 11/9/1999	CLINCH VALLEY PHYSICIANS FOREHAND	1.1 1.42	2.51 3.07		Y Y	63	69	

DX 78	10/31/2000 5/28/2002	THE CLINIC SHERMAN VENTS ARE NOT ACCEPTABLE - ONLY ONE PRE AND POST BRONCHODILATOR EFFECT SUBMITTED							
DX 79	11/6/2001 5/28/2002	THE CLINIC SHERMAN VENT ARE ACCEPTABLE							
DX 85.7	4/18/2002 8/9/2002	SOUTH HILLS PULM. ASSOC. FINO	0.85 1.22	2.23 3.12		Y Y	66	68	G
CX 2	11/7/2002 12/31/2002	VANSANT RESP. CARE VERY SEVERE OBSTRUCTION	0.97	2.49		Y	66	69	G
EE 14	12/9/2002 2/7/2003	CVMC CASTLE SEVERE AIRWAY OBSTRUCTION W/SIGNIFICANT DEGREE OF REVERSIBILITY; LUNG VOLUMES SHOW HYPERINFLATION & AIR TRAPPING; DIFFUSION IS REDUCED	0.82 1.05	1.83 2.6	35	Y Y	66	68	

Medical Reports

EX. NO.	Original Date	Facility Physician Summary	Submitted
DX 13	4/5/1994	IOSIF MOD TO SEVERE RESP IMPAIR, NO XR EVID OF CWP,BUT PROLONGED AND HEAVY EXPO TO COAL DUST WOULD BE MAJOR CONT TO RESP IMPAIR	
DX 14	4/5/1994	IOSIF EKG	
DX 1.19.2	9/20/1995	CLAUSTRO OFF NOTES TO 4-17-96- PT HAS BEEN DIAG WITH ASTHMA WHICH IS WELL COMPENSATED MILD DEGREE AND REVER BY BRONCHODILATION	5/28/1996
DX 1.10	1/17/1996	CVC FOREHAND EKG	
DX 1.9	1/17/1996	CVC FOREHAND CHR BRONCHITIS AND CWP DUE TO CIGARETTE SMOK AND COAL DUST EXPOS	
DX 1.13	3/5/1996	CVC FOREHAND SYMPTOMS HAVE ARISEN IN PART FROM HIS CME AND PRAC OF SMOK CIGAR IS ALSO A MAJOR CONTRIB FACTOR, TOTALLY AND PERM DISABLING RESP IMAPIR, CLINICAL PICTURE IS COMPATIBLE W/ CWP, NEG XR NOTWITHSTANDING	
DX 1.23.5	5/22/1996	MIDWAY MEDICAL GROUP SARGENT EKG	6/24/1996

DX 1.23.3	5/24/1996	MIDWAY MEDICAL GROUP SARGENT RPT ON EXAM OF 5-22-96- NOT SUFFERING FROM CWP- SUFFERS FROM ASTHMA WHICH IS NOT CAUSED BY COAL DUST EXPOS HOWEVER EXPOS TO DUST COULD WORSEN HIS CONDITION	6/24/1996
DX 1.23.2	6/15/1996	MIDWAY MEDICAL GROUP SARGENT CORRECTION TO PRIOR RPT- DIFFUSION CAPACITY ON PFS IS NORMAL, THIS MAKES THIS TEST CONSIS W/ ASTHMA AS OPPOSED TO EMPHY	6/24/1996
DX 1.22	6/19/1996	THE CLINIC FOREHAND HAS REV'D CLAUSTRO NOTES, CLAUSTRO USES THE WORD ASTHMA AS MEANS OF DESCRIBING MECHANISM OF CLMT'S SOB, IT DOES NOT IMPLY CAUSE, CLAUSTRO'S RPTS DO NOT SPECIFICALLY EXCLUDE CWP FROM CONSIDERATION	
DX 1.25	7/19/1996	MICHOS CLMT DOES NOT HAVE A TOTAL RESP DISABILITY FROM CME, WHETHER THIS MINERS'S ASTHMA IS GENETIC OR WHETHER IT IS FROM CME IS DIFFICULT TO ASCERTAIN, FURTHER CME COULD AGGRAVATE HIS COND AND THUS MEET THE LEGAL DEFIN OF CME	
DX 1.28.2	8/8/1996	MIDWAY MEDICAL GROUP SARGENT DEPOSITION TRANSCRIPT	8/22/1996
DX 43.8	9/16/1996	CVC FOREHAND PROGRESS NOTE-XR SHOWS CWP P/P 1/0,CHR BRONCHITIS DUE IN PART AND AGGRAVATED BY COAL DUST W/ LAB ACE TEST	9/23/1998
DX 1.30.2	9/17/1996	CVC FOREHAND RESP IMPAIRMENT OF A MECHANICAL NATURE LEAVES HIM WITH INSUFFICIENT VENT RESERVE TORETURN TO HIS LAST CME, 14 YRS OF SMOKING CONSTITUTES NEARLY AS AN IMPORTANT ETIOLOGY TO HIS RESP IMPAIRMENT AS DOES HIS EXPOS TO COAL DUST	10/17/1996
DX 30	1/7/1997	CVMC CASTLE EKG	3/20/1997
DX 27	3/17/1997	CASTLE CASTLE NO EVID OF CWP, COPD, TOB SMOKE INDUCED, CHRONIC BRONCHITIS, MOD OBS AIRWAYS DIS 2ND TO ABOVE COPD, DOES HAVE MOD PARTIALLY REVERSIBLE RESP IMPAIRMENT DUE TO BOTH BRONCHIAL ASTHMA AND TOB ABUSE, IF PROPERLY TREATED MAY BE ABLE TO RTW	3/25/1997
DX 35	3/18/1997	MIDWAY MEDICAL GROUP SARGENT IOSIF'S FINDINGS OF 4-94 ARE CONSISTENT W/ ASTHMA, NO EVID THAT IT IS POSSIBLE FOR IMPAIRMENT TO BE RELATED TO CME, INADEQUATYE TRMT OF ASTHMA COULD RESULT IN THE TYPE OF IMPAIRMENT SUFFERED BY CLMT, NO DISABILITY DUE TO CME	4/10/1997
DX 36	4/4/1997	CASTLE REVIEW OF ADDITIONAL RECORDS, STILL CLEAR THAT HE HAS EPISODIC ASTHMA, NO EVID THAT COAL DUST CAUSES A PERMANENT AGGRAVATION TO BRONCHIAL ASTHMA IN ANY WAY	4/10/1997
DX 43.2, 43.3	3/25/1998	CLINCH VALLEY PHYSICIANS FOREHAND OFF NOTES TO 6-25-98-CHRONIC BRONCHITIS	9/23/1998
DX 57.3	12/3/1998	PULM OCCUP & RESEARCH CONSULT	8/30/1999

		CASTLE EKG-NON SPECIFIC ST CHANGES	
DX 59.5	7/13/1999	MIDWAY MEDICAL GROUP MCSHARRY EKG-NO ABNORM	9/13/1999
DX 59.2	7/20/1999	MIDWAY MEDICAL GROUP MCSHARRY RPT ON EXAM- DOES NOT HAVE CWP, DOES HAVE SEVERE RESP IMPAIR DUE TO MOST LIKELY A COMB OF ASTHMA AND EMPHYSEMA	9/13/1999
DX 57.2	8/17/1999	PULM OCCUP & RESEARCH CONSULT CASTLE RPT OF 12/3/1998 EXAM- HAS 22PK YR SMOK HIST, DOES NOT SUFFER FROM CWP, MOST LIKELY PERM AND AND TOT DISABLED FROM CME FROM BRONCHIAL ASTHMA	8/30/1999
DX 62.2	10/11/1999	PULM OCCUP & RESEARCH CONSULT CASTLE DEPOSITION TRANSCRIPT	10/14/1999
DX 64.1	10/29/1999	CLINCH VALLEY PHYSICIANS FOREHAND TOT AND PERM DISABLED, DUE IN PART TO CME AND IN PART TO CIGARETTE SMOKING	11/9/1999
DX 63.5	12/15/1999	MIDWAY MEDICAL GROUP MCSHARRY AFTER REVIEW OF FOREHAND RPT AND CASTLE DEP. OPINIONS NOT CHANGED, FOREHANDS PFS MORE IN LINE WITH ADVANCED ASTHMA OR ASTHMATIC BRONCHITIS	1/14/2000
DX 63.6	1/7/2000	PULM OCCUP & RESEARCH CONSULT CASTLE AFTER REVIEWING ADDITIONAL REREADS, FOREHAND RPT AND CASTLE DEP., IT CONTINUES TO BE OPINION THAT CLMT DOES NOT HAVE CWP, IN PARTICULAR FOREHAND PFS SHOWS ASTHMATIC BRONCHITIS, HE IS PERM AND TOT DISABLED FROM THIS, NO DISABILITY RELATED TO CME	1/14/2000
EE 1	8/30/2001	THE CLINIC WHEELER CT SCAN REVIEW, NEGATIVE FOR CWP, ARTERIOSCLEROSIS BOTH CORONARY ARTERIES/CHECK FOR ANGINA PECTORIS	2/7/2003
EE 2	8/30/2001	THE CLINIC SCOTT CT SCAN REVIEW, NEGATIVE FOR CWP, ARTERIOSCLEROSIS AORTA	2/7/2003
DX 77.3	11/3/2001	THE CLINIC FOREHAND LTR TO CLMT; TOTALLY AND PERMANENTLY DISABLED BASED ON RESPIRATORY IMPAIRMENT; OBSTRUCTIVE VENT PATTERN; IMPAIRMENT DUE TO CDE AND SMOKING FOR 24 YEARS; PREDOMINATELY FROM CWP AND LESSER EXTENT FROM SMOKER'S BRONCHITIS	3/12/2002
DX 85.5	5/13/2002	SOUTH HILLS PULMONARY ASSOC FINO EXAM RPT; SMOKED 1PPD FOR 22 YRS FROM 1952-1974; CHEST PAIN; HX OF SINUS PROBLEMS; LUNGS CTA&P; RISK FACTORS ARE CDE, SMOKING HX, ASTHMA; CANNOT COMPLETELY EXCLUDE CDE AS CAUSING SOME IMPAIRMENT; NO CWP; DISABILITY & IMPAIRMENT DUE TO ASTHMA; WOULD BE IN SAME CONDITION HAD HE NEVER WORKED IN MINE	8/9/2002
EE 14	12/9/2002	CVMC CASTLE NORMAL ECG	2/7/2003

EE 14	12/31/2002	PULM OCCUP & RESEARCH CONSULT CASTLE SMOKED FROM AGE 18 UNTIL 1974 (20 PACK YR SMOKING HX); NO EVIDENCE OF CWP; BRONCHIAL ASTHMA; SEVERE AIRWAY OBSTRUCTION; BULLOUS EM; DEGENERATIVE ARTHRITIS; DISABLED DUE TO ASTHMA & SMOKE INDUCED BULLOUS EM	2/7/2003
EE 15	2/11/2003	CASTLE DEPOSITION TRANSCRIPT	2/27/2003

New Evidence

X-rays

The new evidence submitted at hearing includes the reading of an X-ray dated January 7, 2002 by Dr. Thomas Miller, M. D., board certified in diagnostic radiology and a “B” reader. The impression is:

> Findings consistent with pneumoconiosis, category p/s, profusion 1/0. Grade A bilateral pleural thickening, extent 1. Chronic obstructive pulmonary disease (em). thickening of the minor fissure (pi).

CX 1. Dr. Forehand read the same X-ray as p/s, 1/1 (DX 77). Dr. Forehand is a “B” reader, but is not a board certified radiologist.

Evaluating the same X-rays, Dr’s Paul S. Wheeler, William W. Scott and John C. Scatarige all found no evidence of coal workers’ pneumoconiosis (Dx 85). All are board certified in radiology and are laso “B” readers. EE 1, EE 2, EE 3.

The new evidence also contains subsequent X-ray studies taken April 18, 2002, May 13, 2002, June 7, 2002, August 27, 2002, September 17, 2002, December 9, 2002, December 16, 2002, January 15, 2003 and January 29, 2003.See DX 85, DX 86, EE 3, EE 6, EE 7, EE 8, EE 9, EE 10, EE 11, EE 12, EE 13. Dr. Scatarige read five of the six x-ray films as negative. Dr. Scott also read five of the six four films, finding no pneumoconiosis. Dr. Wheeler read two of the six films as negative for pneumoconiosis. Additionally, Dr. Thomas Hayes read the April 18, 2002 X-ray film negative for pneumoconiosis. Dr. Hayes is a board certified radiologist and "B" reader. Dr. Gregory Fino read the April 18, 2002, taken as part of his examination of claimant, and December 9, 2002 x-rays as negative; Dr. A. Dahhan read the September 17, 2002 X-ray as negative and Dr. James Castle read as negative for pneumoconiosis the December 9, 2002 X-ray, which he took during his examination of claimant. Drs. Fino, Dahhan and Castle are "B" readers and board certified pulmonary physicians. Most of the X-ray reports establish that the Claimant has had bullous emphysema throughout the period of claim.

In the prior record, two positive readings were rendered by Dr. J.P. Sutherland, who was not a "B" reader or a radiologist, and Dr. Forehand. However, a total of 67 readings of 24 separate x-ray films have been specifically read as negative for the presence of pneumoconiosis. Those 67 readings were by board certified radiologists and "B" readers, such as Drs. Jerome Wiot, Harold Spitz, Henry Pendergrass, Stephen Fisher, E.N. Sargent, Shiv Navani, William Scott, Paul Wheeler and John Scatarige. Also providing negative readings were "B" readers and board certified pulmonary physicians, such as Drs. J.D. Sargent, Gregory Fino, James Castle and A. Dahhan.

No biopsy or autopsy evidence exists in the record.

The Claimant also offered a letter from Dr. Forehand dated November 2, 2001, in which he concludes that Mr. Richardson is totally and permanently disabled due to respiratory impairment from predominately coal workers pneumoconiosis and to a lesser extent smoker s bronchitis. Dx 77. Dr. Forehand indicated to Mr. Richardson that he had previously been diagnosed as having a respiratory impairment of the ventilatory nature, which was disabling. He stated that his respiratory impairment had arisen from the combined effects of coal dust exposure and smoking cigarettes. He stated that since his chest x-ray did not demonstrate emphysematous changes, he concluded with reasonable confidence that his totally and permanently disabling respiratory impairment had predominantly arisen from coal workers pneumoconiosis and to a lesser extent smoker s bronchitis.

Also included is a Spirometry Report, from Dr. Narayanan, Stone Mountain Respiratory Care, November 6, 2001 (Id.) with measurements: noted as FVC 58%, FEV 1 32% , and MVV 31% (Id). Although the copy at Dx 77 does not include this report, I accept that it exists as it is referred to by Dr. Michael Sherman, who reviewed it for the Department of Labor (DX 78-79), the District Director and by counsel. See Brief and DX 82. Also included was a Plethysmograph Report, from Dr. Forehand, dated October 31, 2000 with an FEV_1 noted as 48%. (Id.) The Claimant later submitted a Spirometry Report from Pat Stapleton, Stone Mountain Respiratory Care, dated November 7, 2002 showing a very severe obstruction. CX 2.

The Employer submitted new evidence, including the new X-ray readings set forth above, and medical reports by Drs. Fino and Castle of their examinations of claimant, relate claimant's respiratory impairment to his asthma. According to these physicians, Claimant has shown no change in conditions on this issue and he previously suffered from asthma unrelated to coal dust exposure and still has asthma unrelated to coal dust exposure.

Dr. Fino, who is board certified in internal medicine and is a “B” reader, determined that based on a thorough examination of the Claimant performed April 18, 2002 and his review of the medical information, including Dr. Forehand’s report, there is no evidence of clinical or legal pneumoconiosis. Moreover, even if it were assumed that Mr. Richardson had legal pneumoconiosis, “I can state with a reasonable degree of certainty that his impairment and disability are due to asthma, and were not caused nor contributed to by the inhalation of coal mine dust. DX 85. Dr. Fino reported Mr. Richardson was a 66 year-old male who had smoked one package of cigarettes daily for 22 years. His medications included Advair, Combivent, and albuterol. He had worked in the mining industry for 39 years until 1994. He spent 37 years underground and two years aboveground. He left the mining industry because of retirement, age, and shortness of breath. His last classified job was as a roof bolting machine operator and shuttlecar operator. This involved heavy labor, especially as a roof bolting machine operator. He complained of shortness of breath for the past 15 years. He became short of breath when walking at his own pace on level ground or climbing one flight of stairs. He had no wheezing. He denied any history of asthma. Pertinent physical findings revealed the lungs were clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs. A chest x-ray was described as showing no abnormalities consistent with an occupationally acquired pneumoconiosis. The film was classified as 0/0. Spirometry was described as showing severe obstruction with a bronchodilator response. The total lung capacity was

elevated and air trapping was present. The diffusing capacity was reduced. Room air arterial blood gases were normal.

Dr. Fino noted three potential risk factors that have resulted or contributed to his respiratory impairment. The first is his coal mine dust exposure, which was 39 years; the second was his smoking history of one pack per day for 22 years, from 1952 to 1974; and the last risk factor is what appears to be strong evidence for the diagnosis of asthma, which, as you know, is a disease of the general medical population. Mr. Richardson did smoke for 22 pack-years, but stopped in 1974. Dr. Fino noted a pulmonary function study from 1973 that was normal, and therefore Dr. Fino ruled out smoking as a cause. Instead he considered coal mine dust inhalation or asthma as possibilities.

He determined that as to the issue of coal mine dust inhalation, Dr. Fino reported that a significant bronchodilator response was seen on almost all of the lung function studies, including the lung function study performed in conjunction with his examination. He related that, "This is pretty classic for asthma, which is a reversible airway obstruction. I would not expect coal mine dust-related lung disease to show this degree of reversibility." Id.

Dr. Fino noted the marked variability of the arterial blood gas studies that sometimes show resting hypoxemia, and at other times are normal, but have always on exercise shown no exercise-induced hypoxemia. He determined that the anomaly is not typical of a coal mine dust related pulmonary condition, since coal mine dust-related pulmonary conditions would be expected to show a drop in the P02 with exercise. Therefore, even if it were assumed that Mr. Richardson had an average loss of FEV1 due to coal mine dust inhalation, Dr. Fino characterized it as "no more than a negligible contribution to his overall impairment and disability. In other words, had he never lost that hypothetical FEV1 due to coal mine dust inhalation, the degree of disability would be the same." Id.

Dr. Castle is also board certified in internal medicine, is a "B" reader and is a pulmonologist. He also examined the Claimant, reviewed all of the records to December 31, 2002, when his report was rendered, and provided deposition testimony on February 11, 2003. His opinion was rendered, with a reasonable degree of medical certainty, based upon a thorough review of all the data including medical histories, physical examinations, radiographic evaluations, physiologic testing, and other data that Mr. Richardson does not suffer from coal workers pneumoconiosis. He reported that Mr. Richardson certainly worked in or around the underground mining industry for a sufficient enough time to have developed coal workers pneumoconiosis if he were a susceptible host. He noted that Mr. Richardson had worked for approximately 40 years in the mining industry and last worked in 1994, and that his last classified job was that of shuttlecar operator/roof bolting machine.

Like Dr. Fino, Dr. Castle considered tobacco and the history of mining and coal dust exposure as possible bases for the test results. According to the report, the physiologic studies that were done and were valid showed evidence of moderately severe airway obstruction associated with hyperinflation, gas trapping, and more recently a reduction in diffusing capacity. There was a very significant degree of reversibility on most occasions. The amount of reversibility was also somewhat variable over time, all of which is consistent with bronchial asthma. Dr. Castle reported that Mr. Richardson has also developed findings that would indicate or confirm the presence of bullous emphysema, namely the reduction in diffusing capacity.

According to Dr. Castle, coal workers pneumoconiosis causes a mixed, irreversible obstructive and restrictive ventilatory impairment when it causes impairment. Those were not the findings in this case He noted that the Claimant has a markedly reversible degree of airway obstruction associated with hyperinflation, gas trapping, and some reduction in diffusing capacity. According to Dr. Castle, All of these findings are indicative of bronchial asthma and tobacco smoke induced bullous emphysema.

Evaluation of the Evidence

Mr. Richardson must demonstrate that there has been a change in conditions or a mistake in determination of fact such that he meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, although Mr. Richardson may be totally disabled from a severe respiratory impairment, he must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2002).

Existence of Pneumoconiosis

The Claimant had failed to establish the existence of pneumoconiosis in the claim prior to current request for modification. The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its *sequelae*, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2002).

20 CFR § 718.202(a) (2002), provides that a finding of the existence of pneumoconiosis may be based on

> (1) chest x-ray,
>
> (2) biopsy or autopsy,
>
> (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability/that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or
>
> (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion.

Neither (2) or(3) above apply in this case. There is no evidence that Mr. Richardson has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, has less than 15 years of work in coal mines/ filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. ***Lane Hollow Coal Co. v. Director, OWCP***, 137 F.3d 799, 803 (4th Cir. 1998). As a general rule, therefore, more weight is given to the most recent evidence. *See* ***Mullins Coal Co. of Virginia v. Director, OWCP***, 484 U.S. 135, 151-152 (1987); ***Eastern Associated Coal Corp. v. Director, OWCP***, 220 F.3d 250, 258-259 (4th Cir. 2000). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. ***Adkins v. Director, OWCP***, 958 F.2d 49 (4th Cir. 1992); ***Burns v. Director, OWCP***, 7 B.L.R. 1-597, 1-600 (1984).

Of the 24 available x-rays in this case, 4 have been read by some but not all reviewers to be positive for pneumoconiosis, and 63 to be negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2002); ***Dixon v. North Camp Coal Co.***, 8 B.L.R. 1-344 (1985); ***Melnick v. Consolidation Coal Co.***, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. ***Roberts v. Bethlehem Mines Corp.***, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. ***Sheckler v. Clinchfield Coal Co.***, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on

each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. See ***Adkins***, 958 F.2d at 52.

I note that whereas both Dr. Miller and Dr. Forehead are "B" readers, Dr. Forehead is not board certified in radiology. I note that Dr's Wheeler, Scott, and Scatarige are dually qualified. I accept that they are more qualified than Dr. Forehead to read the January 7, 2002 X-ray.

I also note that Dr. Miller is the only board certified "B" reader to make a finding that Mr. Richardson has pneumoconiosis based on X-ray evidence. The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990), although it is within my discretion to do so, ***Edmiston v. F & R Coal Co.***, 14 B.L.R. 1-65 (1990). See also ***Schetroma v. Director, OWCP***, 18 B.L.R. 1- (1993) (use of numerical superiority upheld in weighing blood gas studies); ***Tokaricik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease).

I also note that the January 7, 2002 X-ray was followed by a number of other studies, all of which were read as not indicative of pneumoconiosis. Subsequently the Claimant was examined by the employer. Dr. Castle, a "B" reader, also took an X-ray in December, 2002. In weighing x-rays based upon the "later evidence" rule, it is the date of the study, and not the date of the interpretation, which is relevant. ***Wheatley v. Peabody Coal Co.***, 6 B.L.R. 1-1214 (1984). Generally, it is proper to accord greater weight to the most recent x-ray study of record. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149, 1-155 (1989) (en banc); ***Stanford v. Director, OWCP***, 7 B.L.R. 1-541 (1984); ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983).

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction Co.***, 8 B.L.R. 1-65, 1-66 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295, 1-296 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields***, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. ***Clark,*** *supra*. An unsupported medical conclusion is not a reasoned diagnosis. ***Fuller v. Gibraltar Corp.***, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. ***Cosaltar v. Mathies Coal Co.***, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. ***Griffith v. Director, OWCP***, 49 F.3d 184, 186-187 (6th Cir. 1995); ***Justice v. Island Creek Coal Co.***, 11 B.L.R. 1-91, 1-94 (1988); ***Parsons v. Black Diamond Coal Co.***, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. ***Onderko v. Director, OWCP***, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." ***Tedesco v. Director, OWCP***, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2002).

I note that although I accept that Dr. Forehand, as treating physician should be entitled to considerable weight, fails to note the extent and intensity of asthma in his report. DX 77. Both Dr. Castle and Dr. Fino, who also examined the Claimant, explain that the cause of the Claimant's acknowledged respiratory problems is asthma and/or asthmatic bronchitis. DX 85, EE 14, EE 15. I note that Dr. Forehand does, to a lesser extent acknowledge "smoker's bronchitis". DX 77. In testing the Claimant, both Dr. Fino and Dr. Castle found that spirometry was described as showing a severe obstruction with a bronchodilator response. The total lung capacity was elevated and air trapping was present. The diffusing capacity was reduced. Room air arterial blood gases were normal. Whereas pneumoconiosis causes a mixed, irreversible obstructive and restrictive ventilatory impairment when it causes impairment, those were not the findings in this case Both note that the reversibility on testing, indicates that the findings were "classic for asthma". EE 85, EE 14.

I accept that the reports from the Employer witnesses are better documented than those of Dr. Forehand, in that there is repeated testing. ***Fields***, supra. Dr. Forehand did not examine the new X-ray evidence, the test results obtained by Drs. Fino and Castle, and he also relied on his interpretive reading, and I note that he is not as qualified to render an opinion as are the board certified "B" reader radiologists. Therefore, his opinion is also not well reasoned as he relies on a faulty predicate. Id.

I can not credit the reading of Dr. Miller, as the great weight of the evidence can not support a finding that pneumoconiosis is established by X- ray on this basis. I accept that the more recent X-rays are relevant to show that no pneumoconiosis is established on X-ray. See ***Clark***, *supra*.

I also note that the spirometry and blood gas tests by Dr. Castle were performed more than a year after Dr. Forehand's testing, and I accept them as more reliable. Moreover, Dr. Castle had the opportunity to read a more complete record than Dr. Forehand, making his opinion more reliable. Dr. Castle had the opportunity to have examined the Claimant on multiple occasions, in 1997, 1998 and on December 9, 2002. He reviewed the X-rays spirometry, blood gas studies, the Vansant, November7, 2000 spirometry study (CX 2), and testified that there has not been any change in Mr. Richardson's condition, except that the bronchial asthma may be worse. EE 15, at 21. He testified that he "totally" disagrees with Dr. Forehand's conclusion in his November 3,

2001 letter (DX 77). He notes that almost every X-ray reading note that the Miner has bullous emphysema, but that Dr. Forehand failed to address that fact. EE 15 at 24-25. There is no relationship of bullous emphysema to coal workers' pneumoconiosis. Id.

After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Fino and Castle. Both possess excellent credentials in the field of pulmonary disease. Both had the opportunity to examine the Claimant as well as to review other medical evidence in the record. I also find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by the physicians who concluded that the Claimant was not disabled by pneumoconiosis. Drs. Castle and Fino better explained how all of the evidence they developed and reviewed supported their conclusions.

Although I credit the Claimant's testimony that his symptoms are more severe, I do not accept that pneumoconiosis is a factor.

CONCLUSION

After a review of the entire claim, there was no mistake in a determination of fact or law in the prior record. Moreover, the Claimant has not proved that he has had a "change in conditions" since his prior determination, in that there has been no change in the claimant's physical condition relating to pneumoconiosis. 33 U.S.C. § 922; 20 C.F.R. § 725.310. The Claimant has failed to establish that he has pneumoconiosis, which is a crucial element of proof. ***Oggero*** , *supra*.

A

DANIEL F. SOLOMON
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.

1. ***Qualifications**
A = A reader

B = B reader
O = Other
***Certifications**
R = Board Certified Radiologist
E = Board Eligible Radiologist
P = Pulmonologist
O = Other
U = Unknown

2. ***Rest**
****Exercise**